ADVANTAGES OF SKELETAL TRACTION

The advantages of skeletal traction for fractures of the shaft of the femur is well known. Its use through the olecranon for the fractures of the humerus is also common practice. The use of skeletal traction in fractures of the radius and ulna is a newer development and promises much. Traction through the phalanges for fractures of the metacarpal bones or phalanges themselves is becoming increasingly popular. Traction through the metatarsals with countertraction through the os calcis is being used with excellent results in compression fractures of the tarsal bones or in the reduction of some of the difficult transtarsal fracture dislocations. Traction through the metacarpals with countertraction through the olecranon process will often allow easy reduction of compression fractures and dislocations of the carpal bones.

Handled rightly, skeletal traction represents an ideal method. It is, however, a very exacting one and the surgeon must be familiar with all the problems at hand to handle it successfully. The question of infection about a pin through a bone is best solved by rendering the area aseptic and sealing it so and not disturbing it until the pin is removed. The secret in the keeping of a skeletal traction pin free from later infection, I believe, lies in seeing that the pin is firmly placed so that there is no motion at all between it and the bone, or it and the soft tissues. It must not be allowed to slide laterally or angulate. The technique I have found successful is as follows:

1. Sterilize the parts as for any clean operative procedure.

2. Insert the pin, making a nick in the skin only at the point of entrance and exit. See that the pin is directed at right angles to the line of traction.

3. Seal the wounds, after applying iodin and alcohol, with a circular gauze pad saturated with compound tincture of benzoin.

4. If the collar does not fit snugly (is too large, it must not be applied too small) block the space between the dressing and the collar with suitable-sized cork or rubber washer. A wet, inch-size plaster-paris bandage can be made to answer the same purpose easily.

5. Do not disturb dressings, pin, or collar unless there is a definite indication.

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BLADDER NECK PATHOLOGY IN THE FEMALE

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MANY irritable bladder necks and urethral inflammations in the female are often diagnosed by the attending physician as cystitis.

Now cystitis *per se* is a mucosal reaction within the bladder which produces the classical symptoms coincident with such conditions. While the most common symptom is urinary frequency, yet dysuria and hematuria may be present. The true cystitis of bacteremic origin is quite constantly secondary to some distant pathological focus. If, however, the bladder reaction is due to some local disturbance, then stone, tumor, or an extravesical obstructive factor is the cause commonly expected by the urologist.

A careful urological examination is necessary in order to differentiate the true cystitis from another bladder condition met within the female.

Presented to the clinician quite frequently is the female patient complaining of occasional attacks of mild urinary frequency with or without burning on urination. Investigation of this type of patient will reveal no bladder pathology to account for existing symptoms except an inflamed or edematous bladder neck with occasional small polypoid protrusions. Urethroscopic exploration of the urethra will show a moderate inflammatory mucosal reaction with considerable urethral tenderness upon palpation.

The probability is that the bladder neck reaction is secondary to a primary urethritis which had its origin in repeated trauma. The female urethra being, by virtue of its location, quite susceptible to bacterial invasion, becomes rather easily infected in view of the traumatized mucosa. Considering the fact that the majority of such cases is observed in married women, the cause of such urethral injury is rather easy to imagine.

The urinary changes in these patients are quite characteristic in that Thompson's two-glass test will show a hazy first and clear second. If one use care in carefully cleansing the urethral meatus and its surrounding area, the two-glass test will be found very helpful as an aid in examination.

In the consideration of the patient who complains of so-called bladder symptoms, the general clinician should be ever on his guard in order to differentiate between a cystitis and an irritable bladder neck with urethritis.

The curative procedures in the case of cystitis have for their direct purpose the eradication of the primary etiologic factors with treatment directed at the inflamed mucosa.

In the patient with bladder neck pathology and urethritis, the causative factor must be removed and treatment directed to clear the local condition present. This type of patient is usually subjected to repeated bladder irrigations and the injection of urinary antiseptics, all of which do no good and can only discredit the ability of him who is ever so anxious to effect a cure.

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One of the most important lessons that we should appreciate is the great complexity and the vast scope of the field of public health. It is not a definite science, but comprises a great body of knowledge about as broad as experimental science itself. For that reason the study of public health should be excellently adapted for general educational purposes. In this field, not only are the fundamentals of practically every laboratory science applied, but here is ample opportunity for the study of classics, the humanities, social problems, and economics; for all civilizations have been profoundly influenced by problems of health and disease. (D. J. Davis, *Illinois Medical Journal*, November, 1929.) —*Weekly Bulletin, California Department of Public Health.*